

ACP Pushes Quality as Key Role for EHRs

BY MARY ELLEN SCHNEIDER

TORONTO — For electronic health records to have real value, physicians need to use them to improve quality, and not just to improve documentation and coding.

That's the message the American College of Physicians is sending to doctors, policy makers, and the health information technology industry with the release of a position paper on EHR-based quality measurement and reporting. Released in April during the ACP's annual meeting, the paper outlines several objectives to maximize the use of EHRs for reporting quality measures. For example, EHR-based quality reporting should use only those measures that are clinically relevant and that help improve outcomes.

The ACP also advised that any EHR-based measurement should use information that is routinely collected during a visit, including data provided by patients. This will likely require EHR systems to include new functionalities that are not part of today's standard systems, such as practice-based registries that allow reporting on a population of patients, as well as connections to patient portals.

It's critical that the collection of information does not create another administrative burden for physicians, said Dr. Michael S. Barr, the ACP's vice president for practice advocacy and improvement. "If we layer additional processes onto the daily workload of doctors, especially without taking away other responsibilities, we won't get the potential of EHRs because physicians will not implement them the way we're talking about," he said.

The paper also emphasizes the need for EHRs to provide real-time clinical decision support systems that are linked to quality reporting. This type of functionality would allow physicians to get patient-specific recommendations after entering routine clinical information into the system.

This kind of real-time feedback has been lacking in current quality reporting programs such as Medicare's Physician Quality Reporting Initiative (PQRI), said Dr. Joseph W. Stubbs, ACP president. Dr. Stubbs said there is often a long lag time between when physicians report on measures and when they receive reports on their performance under PQRI. For example, he submitted his final 2008 quality measures in December 2008 and did not receive feedback until October 2009.

Most current EHR systems can't provide the level of functionality described in the ACP's policy paper. But technology is not the major obstacle, Dr. Barr said. A bigger barrier is the cultural change required of each member of the clinical team in rethinking the office workflow as part of EHR implementation, he said.

The other hurdle for implementing widespread use of EHRs for quality reporting is the physician payment system. The current volume-based payment system doesn't allow physicians to be paid for actually improving quality, Dr. Stubbs said. "Without the business model for practicing better quality of care, it's an extraordinarily expensive prospect for physicians, particularly in small groups, to think about putting in an electronic health record," he said.

Despite these obstacles, the ACP is encouraging its members to adopt EHRs, and is launching new resources for evaluating the technology. At the annual meeting, the ACP demonstrated its new AmericanEHR Partners program (www.americanehr.com), a Web site that will provide comparisons of EHR products, information on physician experiences with the technology, and opportunities for online social networking. The resources will be free and open to all physicians, not just ACP members. AmericanEHR Partners is expected to be live by early June.

The focus on using EHRs for quality comes as the federal government is finalizing regulations on what constitutes

"meaningful use" of EHRs, the standard for qualifying for Medicare and Medicaid incentive payments under the Health Information Technology for Economic and Clinical Health Act. Physicians who demonstrate meaningful use of certified EHR technology can earn up to \$44,000 in bonus payments under Medicare starting in 2011. A similar program under Medicaid allows eligible physicians to earn nearly \$64,000 in incentive payments.

Dr. Stubbs said the federal incentives could be a big boost for physicians looking to purchase EHR systems. But the success of the program depends on whether the meaningful use criteria can actually be achieved. The worst thing would be for physicians to invest money up front to purchase EHRs, but find out later that they fell short of meaningful use by one measure and thus won't get any incentive dollars. "That would do

more to destroy the effort than anything," Dr. Stubbs said.

As written, the proposed rule on meaningful use is not achievable, said Dr. Peter Basch, medical director for ambulatory, EHR, and health IT policy at MedStar Health in the Baltimore-Washington area. But Dr. Basch, who also is a member of the ACP's Medical Informatics Subcommittee, said he is hopeful that the Centers for Medicare and Medicaid Services will modify the requirements so that the average physician can achieve meaningful use in 2011 or 2012. "These are dollars they do want to pay out," he said. "They do want to make this reasonable for doctors to do." ■

The ACP position paper is available online at www.acponline.org/advocacy/where_we_stand/health_information_technology/ehrs.pdf.

Small Practices Benefit Less From EHRs

The return on investment that physicians can expect to see after implementing an electronic health record is likely to differ greatly based on the size of their practice, according to one health information technology expert.

In large practices, physicians can anticipate significant cost reductions from elimination of chart pulls and improved intra-office communication. And such practices are likely to achieve savings from improvements in process throughput, coding, elimination of transcription, reductions in physician-to-staff ratios, and increased productivity, Dr. Basch said.

But the return on investment equation is quite different for small practices, Dr. Basch said. For example, small practices can't bank on saving much by reducing or eliminating chart pulls, because they typically keep charts right in the office and don't pay \$8-\$15 per chart pull the way large practices do. Small practices have the potential to reduce some staff following EHR adoption, but that won't happen immediately. Also, if the practice is already fairly lean there may not be much trimming of staff costs, he said.

The greatest potential for savings comes from better coding and the elimination of transcription. "Most of us tend to undercode, and EHRs can help us with coding," Dr. Basch said.

Small practices have additional obstacles when implementing an EHR, he noted. They generally don't have sufficient capital to invest in an expensive system, so they have to borrow money or take a reduction in income during the initial start-up period. Practices that aren't interested in taking out loans or reducing their income can consider an application service provider model, which essentially allows them to lease an EHR system. This isn't a good fit for every practice, Dr. Basch said, but it is attractive because it doesn't involve a large cash outlay upfront.

For practices considering the leasing approach, the monthly cost will be important. Those costs have typically ranged from \$500 to \$1,000 per month, but they appear to be coming down, Dr. Basch said. "As those monthly figures begin to move down because of market pressure, this could certainly make an EHR investment a lot more affordable for many, many people," he said.

Two EHR Certification Programs Proposed by Federal Agency

The federal government has put forward its plan to test and certify electronic health records in preparation for the Medicare and Medicaid incentive program that will reward physicians for the use of health information technology.

The proposed rule establishes a temporary certification program in which the National Coordinator for Health Information Technology, Dr. David Blumenthal, will designate certain organizations to test and certify complete EHRs and related modules.

Under the temporary program, Dr. Blumenthal's office would take on many of the functions, such as accreditation, that will later be performed by private groups. The idea behind the temporary program is to ensure that certified EHR products are available before the first in-

centives for use of certified systems begin in 2011.

The rule also proposes the creation of a permanent certification program that would eventually replace the temporary one. The permanent program would be more sophisticated, dividing the responsibility for testing and certification among different organizations. The permanent program also would include accreditation processes and set forth the requirement that certification bodies perform surveillance of certified EHR products. Certification bodies also may be able to assess additional health information technology products beyond EHRs and their modules.

Both certification programs would be voluntary.

—Mary Ellen Schneider

INDEX OF ADVERTISERS

Bayer HealthCare LLC		Merck & Co., Inc.	
Aspirin	49	Janumet	20a-20b, 21
Daiichi Sankyo, Inc.		Novo Nordisk Inc.	
Welchol	12a-12b	Levemir	7-8
Forest Pharmaceuticals, Inc.		NovoLog	31-32
Namenda	4a-4b	Pfizer Inc.	
Lexapro	15-19	Pristiq	55-56
Bystolic	27-30	Purdue Pharma L.P.	
Savella	41-44	OxyContin	22-25
GlaxoSmithKline Consumer Healthcare		URL Pharma	
Tums	6	Colcry	11-12
Lilly USA, LLC		US Oncology, Inc.	
Evista	34-37	Corporate	9
Massachusetts General Hospital			
Corporate	46		